

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
SOUTHERN DIVISION
No. []:[][]-cv-[][][][]-[][]**

**IN RE: CAMP LEJEUNE
WATER LITIGATION**

/

THIS DOCUMENT RELATES TO:

**DISCOVERY POOL PROFILE
FORM**

| | | | |
|-----------------|--------|--------|--------|
| XXXXXX | X | XXXXXX | XX |
| Plaintiff First | Middle | Last | Suffix |

In completing this Discovery Pool Profile Form (“DPPF”), you must provide information that is true and accurate to the best of your knowledge. In completing this DPPF, you are under oath and subject to the penalties of perjury. The DPPF shall be completed pursuant to the September 26, 2023 *Case Management Order No. 2*. (Doc. 23). Plaintiff reserves the right to supplement all responses. For each question where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete. Please answer each question and do not leave any blanks. If appropriate, you may respond in good faith that you do not know or do not recall. If you do not know or do not recall the information requested, please provide as much information as you can. All aspects of this DPPF are designated as “Confidential Information” and covered by the Protective Order, D.E. 36.

I. CLAIMANT INFORMATION

| | | | |
|--|---|--|----------------------------------|
| 1. What is the DON Claim Number for the administrative claim (Short Form Complaint, Box 30)? <i>E.g., CLS23-123456</i> | | [] [] [] []- [] [] [] [] <input type="checkbox"/> DON has not yet assigned a claim number | |
| 2. Who is completing this Discovery Pool Profile Form? | | <input type="checkbox"/> Plaintiff or Plaintiff's Agent <input type="checkbox"/> Attorney for Plaintiff or Attorney for Plaintiff's Agent | |
| If this Discovery Pool Profile Form is being completed by an attorney, please identify the attorney: | | | |
| 3. Attorney first name | [] [] | | |
| 4. Attorney last name | [] [] [] [] | | |
| 5. Law firm name | [] [] [] [] | | |
| 6. Attorney address line 1 | [] [] | | |
| 7. Attorney address line 2 | [] [] [] [] | | |
| 8. Attorney city | [] [] [] [] | | |
| 9. Attorney state (abbrev.) | [] [] | | |
| 10. Attorney zip code | [] [] [] [] | | |
| 11. Attorney phone | ([] [] [] [] [] []) - ([] [] [] [] [] []) | | |
| 12. Attorney email | [] [] [] [] | | |
| Resume universal questions | | | |
| 13. What is the case number? <i>E.g., 7:23-cv-12345</i> | | [] : [] [] - cv - [] [] [] [] | |
| 14. Which District Judge is assigned to the case? | | <input type="checkbox"/> Hon. Richard E. Myers II <input type="checkbox"/> Hon. Terrence W. Boyle <input type="checkbox"/> Hon. Louise W. Flanagan <input type="checkbox"/> Hon. James C. Dever III | |
| 15. Please identify any other names the Plaintiff has used, if different from that in the case caption (e.g., maiden name). | | [] [] [] - [] [] - [] [] [] [] | |
| 16. Please identify the Plaintiff's Social Security Number. | | [] [] [] - [] [] - [] [] [] [] | |
| 17. Please identify the Plaintiff's date of birth. | | MM/DD/YYYY | |
| 18. Please identify the Plaintiff's last known address: | | | |
| 18a. Street Address | 18b. Town | 18c. State (abbrev.) | 18d. Year residence began (YYYY) |
| | | | |
| 19. If the Plaintiff began residing at the above address <i>after</i> 2020, please identify the next most recent address: | | | |
| 19a. Street Address | 19b. Town | 19c. State (abbrev.) | 19d. Year residence began (YYYY) |
| | | | |
| 20. On your Short Form Complaint , did you assert a claim for injuries to YOU or to SOMEONE ELSE you legally represent? (Box 1) | | <input type="checkbox"/> To Me <input type="checkbox"/> Someone Else | |

If you assert a claim for injuries to SOMEONE ELSE, please describe your representation of that person:

| 21. What is the nature of the representative's representation? | | <input type="checkbox"/> Estate Administrator/trix <input type="checkbox"/> Guardianship <input type="checkbox"/> Conservatorship <input type="checkbox"/> Power of attorney <input type="checkbox"/> Other: _____ | | | |
|---|--|---|--|--|--|
| 22. Has a court appointed you as the claimant's representative? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 23. If yes, please describe your appointment: | | | | | |
| 23a. Court Name | 23b. Court State (abbrev.) | 23c. Date of appointment | | | |
| Resume universal questions | | | | | |
| 24. On your Short Form Complaint, did you assert that the Plaintiff is deceased? (Box 7) | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If the Plaintiff is deceased: | | | | | |
| 25. How many dependents, if any, did Plaintiff have at the time of Plaintiff's death? | | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/> I do not know/do not recall | | | |
| 26. Please identify Plaintiff's spouse and children at the time of death. If none, check here: <input type="checkbox"/> No Spouse or Children at time of death | | | | | |
| 26a. First name | 26b. Middle Name | 26c. Last name | 26d. Suffix | 26e. Relationship to Plaintiff | 26f. Year of birth |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____ | YYYY <input type="checkbox"/> I do not know/do not recall |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____ | YYYY <input type="checkbox"/> I do not know/do not recall |

| | | | | | |
|--|--|--|--|--|--|
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____ | YYYY <input type="checkbox"/> I do not know/do not recall |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____ | YYYY <input type="checkbox"/> I do not know/do not recall |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____ | YYYY <input type="checkbox"/> I do not know/do not recall |

II. MILITARY SERVICE & DEPENDENT MEDICAL

a) Military service

| | |
|--|--|
| Resume universal questions | |
| 27. Has Plaintiff <i>ever</i> served in a branch of the U.S. military? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| If the Plaintiff has previously served in the U.S. military: | |
| 28. Did the Plaintiff's service overlap with any of the following conflict periods? | <input type="checkbox"/> WWI <input type="checkbox"/> WWII <input type="checkbox"/> Korea <input type="checkbox"/> Vietnam <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A (e.g., only served during peacetime) |

| 29. What was the Plaintiff's service number? | | | <input type="checkbox"/> N/A (e.g., service after 1970) <input type="checkbox"/> I do not know/do not recall |
|---|--|--|--|
| 30. For each period of service, please identify: | | | |
| 30a. Service Branch | 30b. Year service began | 30c. Year service ended | 30d. Officer or Enlisted |
| <input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall |
| <input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall |
| <input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall |
| <input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <ol style="list-style-type: none"> YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall |

b) *Veteran and dependent medical*

| | | |
|--|--|---|
| Resume universal questions | | |
| 31. Is/was Plaintiff a TRICARE beneficiary? | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| If the Plaintiff is or was a TRICARE beneficiary: | | |
| 32. Did someone else sponsor the Plaintiff's TRICARE benefits? | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| If someone else sponsored the Plaintiff's TRICARE Benefits | | |
| 33. Sponsor/Veteran First Name | | |
| 34. Sponsor/Veteran Middle Name | | |
| 35. Sponsor/Veteran Last Name | | |
| 36. Sponsor/Veteran SSN | | <ol style="list-style-type: none"> [][][]-[][][]-[][][] <input type="checkbox"/> I do not know/do not recall |

| | |
|--|--|
| 37. Sponsor/Veteran Branch of Service | <input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> I do not know/do not recall |
| 38. Claimant relationship with Sponsor/Veteran | <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall |

Other Service/Employment

| Resume universal questions | | |
|---|---|--|
| 39. On your Short Form Complaint, did you assert that the Plaintiff was a Civilian Employee of a Private Company at Camp Lejeune? (Box 17) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 40. [If yes] Please identify: | | |
| 40a. Plaintiff's Employer (Private Company) | 40b. Date employment began | 40c. Date employment ended |
| _____ | MM/DD/YYYY | MM/DD/YYYY |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall |
| _____ | MM/DD/YYYY | MM/DD/YYYY |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall |
| _____ | MM/DD/YYYY | MM/DD/YYYY |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall |
| 41. On your Short Form Complaint, did you assert that the Plaintiff was a Civil Service Employee at Camp Lejeune? (Box 17) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 42. [If yes] Please identify: | | |
| 42a. Plaintiff's Employer (Agency) | 42b. Date employment began | 42c. Date employment ended |
| _____ | MM/DD/YYYY | MM/DD/YYYY |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall |

| | | |
|---|--|--|
| _____ | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall |
| _____ <input type="checkbox"/> I do not know/do not recall | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall |

III. DISEASES AND ILLNESSES

Resume universal questions

| | |
|---|--|
| <p>43. What diseases or injuries does the claimant assert are related to exposure to water at Camp Lejeune? (choose all that apply)</p> | <input type="checkbox"/> Bladder cancer <input type="checkbox"/> Kidney cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Non-Hodgkin's lymphoma <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Adverse Birth Outcomes <input type="checkbox"/> ALS <input type="checkbox"/> Aplastic anemia or myelodysplastic syndromes <input type="checkbox"/> Bile duct cancer <input type="checkbox"/> Brain/CNS cancer <input type="checkbox"/> Breast cancer <input type="checkbox"/> Cardiac birth defects <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Gallbladder cancer <input type="checkbox"/> Hepatic steatosis <input type="checkbox"/> Hypersensitivity skin disorder <input type="checkbox"/> Infertility <input type="checkbox"/> Intestinal cancer <input type="checkbox"/> Non-cancer kidney disease <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver cancer <input type="checkbox"/> Lung cancer <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Neurobehavioral effects <input type="checkbox"/> Non-cardiac birth defects <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Sinus cancer <input type="checkbox"/> Soft tissue cancer <input type="checkbox"/> Systemic sclerosis/scleroderma <input type="checkbox"/> Thyroid cancer <input type="checkbox"/> Other: _____ |
|---|--|

a) *Injury 1 – repeat questions for each injury asserted*

| | |
|---|--|
| 44. I am completing this section as it relates to: | <input type="checkbox"/> Bladder cancer <input type="checkbox"/> Kidney cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Non-Hodgkin's lymphoma <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Adverse Birth Outcomes <input type="checkbox"/> ALS <input type="checkbox"/> Aplastic anemia or myelodysplastic syndromes <input type="checkbox"/> Bile duct cancer <input type="checkbox"/> Brain/CNS cancer <input type="checkbox"/> Breast cancer <input type="checkbox"/> Cardiac birth defects <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Gallbladder cancer <input type="checkbox"/> Hepatic steatosis <input type="checkbox"/> Hypersensitivity skin disorder <input type="checkbox"/> Infertility <input type="checkbox"/> Intestinal cancer <input type="checkbox"/> Non-cancer kidney disease <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver cancer <input type="checkbox"/> Lung cancer <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Neurobehavioral effects <input type="checkbox"/> Non-cardiac birth defects <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Sinus cancer <input type="checkbox"/> Soft tissue cancer <input type="checkbox"/> Systemic sclerosis/scleroderma <input type="checkbox"/> Thyroid cancer <input type="checkbox"/> Other: _____ |
| 45. Has a physician diagnosed the Plaintiff with this injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |
| 46. If yes, when was Plaintiff first diagnosed this injury? | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |

| 47. Name of physician that first diagnosed the Plaintiff? | | | | Name _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | | | |
|--|-------------------------------|--------------------------|-----------------------|---|------------------|--|---|
| 48. Name of hospital or medical group of physician: | | | | Name _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | | | |
| 49. Do you allege that this Injury caused or contributed to the Plaintiff's death? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | | | |
| 50. List all treating physicians, name of medical group, and city, state where treatment was received. If none, check here: <input type="checkbox"/> No treatment. | | | | | | | |
| 50a. First name, if known | 50b. Middle Initial, if known | 50c. Last name, if known | 50d. Suffix, if known | 50e. Medical Group | 50f. City, State | 50g. Year(s) of Treatment | 50h. Was this covered by TRICARE |
| | | | | | | _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |

IV. EXPOSURES

| | | | |
|--|--|---|--|
| Resume universal questions | | <input type="checkbox"/> Residential (living on-base) <input type="checkbox"/> Occupational (working on-base) <input type="checkbox"/> In utero <input type="checkbox"/> Other (e.g., visiting/recreation) | |
| 51. Please select all of the types of exposure you allege: | | | |

| | |
|--|--|
| 52. Please select all of the areas on base in which Plaintiff lived. | <input type="checkbox"/> Tarawa Terrace (includes Tarawa Terrace I, Tarawa Terrace II, Camp Knox Trailer Park) <input type="checkbox"/> Hadnot Point (includes Mainside barracks, French Creek, and Hospital Point) <input type="checkbox"/> Montford Point (includes Camp Johnson) <input type="checkbox"/> Holcomb Boulevard (includes Berkeley Manor, Midway Park, Paradise Point, Watkins Village) <input type="checkbox"/> Courthouse Bay <input type="checkbox"/> New River Air Station (includes MCAS New River and Camp Geiger); <input type="checkbox"/> Onslow Beach <input type="checkbox"/> Rifle Range <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |
| 53. Was the Plaintiff residing with a servicemember during the period of exposure (e.g., parent or spouse), including in utero exposures? | <input type="checkbox"/> Yes, residing with a servicemember parent <input type="checkbox"/> Yes, residing with a servicemember spouse <input type="checkbox"/> Yes, residing with someone else who was a servicemember <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| 54. If the Plaintiff was residing with a servicemember during the period of exposure, please identify the servicemember: | |
| 55. Servicemember First Name | |
| 56. Servicemember Middle Name | |
| 57. Servicemember Last Name | |
| 58. Servicemember SSN | [] [] []-[] [] [] [] <input type="checkbox"/> I do not know/do not recall |
| 59. Servicemember Date of Birth | _____ MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall |
| 60. Servicemember Branch of Service | <input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> I do not know/do not recall |

| | |
|---|---|
| 61. Servicemember Service Number | <input type="text"/> <input type="checkbox"/> N/A (e.g., service after 1970) <input type="checkbox"/> I do not know/do not recall |
| 62. Claimant relationship with Servicemember at the time of exposure. | <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall |
| Complete this section only if alleging in utero exposures: | |
| 63. Please select all of the areas on base in which Plaintiff's mother lived when the Claimant was in utero: | <input type="checkbox"/> Tarawa Terrace (includes Tarawa Terrace I, Tarawa Terrace II, Camp Knox Trailer Park) <input type="checkbox"/> Hadnot Point (includes Mainside barracks, French Creek, and Hospital Point) <input type="checkbox"/> Montford Point (includes Camp Johnson) <input type="checkbox"/> Holcomb Boulevard (includes Berkeley Manor, Midway Park, Paradise Point, Watkins Village) <input type="checkbox"/> Courthouse Bay <input type="checkbox"/> New River Air Station (includes MCAS New River and Camp Geiger) <input type="checkbox"/> Onslow Beach <input type="checkbox"/> Rifle Range <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |
| 64. Did Plaintiff's mother work at Camp Lejeune as a federal civilian employee when the claimant was in utero? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| 65. If yes, what was the name of the government employer? | <input type="text"/> <input type="checkbox"/> I do not know/do not recall |

V. PERSONAL HISTORY

| | |
|---|---|
| Resume universal questions | |
| 66. Was the Plaintiff ever exposed to Agent Orange? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |

| | |
|--|--|
| 67. Was the Plaintiff ever exposed to open air burn pits? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| 68. Other than time spent residing at Camp Lejeune, was the Plaintiff ever employed in any of the following occupations? Check all that apply. | <input type="checkbox"/> Dry cleaning <input type="checkbox"/> Firefighter <input type="checkbox"/> Hairdresser/barber <input type="checkbox"/> Metal degreasing <input type="checkbox"/> Oil & gas <input type="checkbox"/> Painter <input type="checkbox"/> Road Construction <input type="checkbox"/> Textile Manufacturing <input type="checkbox"/> Welder <input type="checkbox"/> None of the Above <input type="checkbox"/> I do not know/do not recall |

Add'l Personal History

| Resume universal questions | | | | | | |
|--|---|--|---|--|---|---|
| 69. Please identify the highest academic degree claimant attained or <input type="checkbox"/> I do not know/do not recall. | | | | | | |
| 69a. Name of institution | 69b. City, State | 69c. Year attendance began | 69d. Year attendance ended | 69e. Degree attained (e.g., B.A., M.D., Ph.D.) | 69f. Field of study | 69g. Degree awarded? |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | YYYY <input type="checkbox"/> I do not know/do not recall | YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| 70. Did the Plaintiff ever possess an occupational certification or license? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall | |
| 71. [If yes] What occupational certifications or licenses did the Plaintiff possess? | | | | | | |
| 72. Please identify all family grandparents, parents, siblings, or children of the Plaintiff who have ever been diagnosed with any of the disease identified on the Claimant's Short Form Complaint. | | | | | | |
| 72a. Name | 72b. Relationship | 72c. Year of birth | 72d. Cancer or disease | | 72e. Year of diagnosis | |
| <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Grandparent <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Children <input type="checkbox"/> Other: <input type="checkbox"/> I do not know/do not recall | YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Bladder cancer <input type="checkbox"/> Kidney cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Non-Hodgkin's lymphoma <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other: _____ | | YYYY <input type="checkbox"/> I do not know/do not recall | |

VI. ECONOMIC LOSS

| | |
|--|---|
| Resume universal questions | |
| 73. Are you seeking recovery for economic loss, such as out-of-pocket medical costs or lost earnings? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Following questions available only if answer to Question 73 = "Yes" | |
| 74. Has the Plaintiff ever paid or incurred any out-of-pocket medical expenses (i.e. expenses not paid by your insurance company or by a government health program) related to any condition caused by exposure to water at Camp Lejeune? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 75. Has the Plaintiff ever paid or incurred any out-of-pocket non-medical expenses (i.e. expenses not paid by your insurance company or by a government health program) related to any condition caused by exposure to water at Camp Lejeune? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 76. Has an injury related to Camp Lejeune water caused the Plaintiff to be unable to work? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

VII. PRIOR CLAIMS

| | |
|---|---|
| Resume universal questions | |
| 77. Did the Plaintiff (or someone else on the Claimant's behalf) ever file a civil litigation complaint against the United States related to contaminated water at Camp Lejeune before August 11, 2022? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| Following questions available only if answer to question 77 = "Yes" | |
| 78. What was the caption (the title or name) of the prior litigation? | |
| 79. In what court was the prior litigation filed? | United States District Court for the _____ District of _____ |
| 80. What was the case number? | |
| 81. Was the case consolidated in a multi-district litigation? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| Back to universal questions | |
| 82. Has the Plaintiff filed a bankruptcy petition since August 10, 2022? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall |
| Following questions available only if answer to question 82 = "Yes" | |
| 83. On what date did the Plaintiff petition for bankruptcy? | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |
| 84. In what court did the Plaintiff file the bankruptcy petition? | United States Bankruptcy Court for the _____ District of _____ |
| 85. What is the case number for the Plaintiff's bankruptcy petition? | |

Add'l Prior claims

| Back to universal questions | | | | |
|--|---|---|---|---|
| 86. Has the Plaintiff ever filed a disability claim with a state agency for the injuries identified in the Short Form Complaint? | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall | | |
| 87. [If yes] Please describe the nature of the disability claim and any award: | | | | |
| 87a. Name of agency where claim was filed | 87b. Description of claim and disability | 87c. Date claim was filed | 87d. Whether Plaintiff was awarded disability | 87e. Amount received in disability (or \$0 if none awarded) |
| | | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall | \$ _____ |
| | | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall | \$ _____ |
| | | MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall | \$ _____ |
| 88. Did the Plaintiff (or someone else on the claimant's behalf) ever file a civil litigation complaint related to exposures to Agent Orange? | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall | | |
| 89. [If yes] Please identify: | | | | |
| 89a. Case caption | 89b. Court where the litigation was filed | 89c. Case number | 89d. Amount of compensation received from the lawsuit (or \$0 if none awarded) | |
| | | | \$ _____ | |
| 90. Did the Plaintiff (or someone else on the claimant's behalf) ever file a civil litigation complaint related to exposures to glyphosate (Round-Up)? | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall | | |
| 91. [If yes] Please identify: | | | | |

| | | | |
|-------------------|---|------------------|--|
| 91a. Case caption | 91b. Court where the litigation was filed | 91c. Case number | 91d. Amount of compensation received from the lawsuit (or \$0 if none awarded) |
| | | | |

VIII. ADDITIONAL NOTES AND COMMENTS

| <u>Question No.</u> | <u>Comment</u> |
|---------------------|----------------|
| | |

PLAINTIFF CERTIFICATION OF DPPF

I, _____, certify that the information herein and/or supporting the attached Discovery Pool Profile Form is true and accurate to the best of my knowledge, information, and belief. I declare under penalty of perjury that the foregoing is true and correct.

[Plaintiff Name]

INSERTS FOR ADDITIONAL INJURIES

a) *Injury [] – repeat questions for each injury asserted (if needed)*

| | |
|---|--|
| 92. I am completing this section as it relates to: | <input type="checkbox"/> Bladder cancer <input type="checkbox"/> Kidney cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Non-Hodgkin's lymphoma <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Adverse Birth Outcomes <input type="checkbox"/> ALS <input type="checkbox"/> Aplastic anemia or myelodysplastic syndromes <input type="checkbox"/> Bile duct cancer <input type="checkbox"/> Brain/CNS cancer <input type="checkbox"/> Breast cancer <input type="checkbox"/> Cardiac birth defects <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Gallbladder cancer <input type="checkbox"/> Hepatic steatosis <input type="checkbox"/> Hypersensitivity skin disorder <input type="checkbox"/> Infertility <input type="checkbox"/> Intestinal cancer <input type="checkbox"/> Non-cancer kidney disease <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver cancer <input type="checkbox"/> Lung cancer <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Neurobehavioral effects <input type="checkbox"/> Non-cardiac birth defects <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Sinus cancer <input type="checkbox"/> Soft tissue cancer <input type="checkbox"/> Systemic sclerosis/scleroderma <input type="checkbox"/> Thyroid cancer <input type="checkbox"/> Other: _____ |
| 93. Has a physician diagnosed the Plaintiff with this injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |
| 94. If yes, when was Plaintiff first diagnosed this injury? | _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |

| 95. Name of physician that first diagnosed the Plaintiff? | | | | Name _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | | | |
|--|-------------------------------|--------------------------|-----------------------|---|------------------|--|---|
| 96. Name of hospital or medical group of physician: | | | | Name _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | | | |
| 97. Do you allege that this Injury caused or contributed to the Plaintiff's death? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | | | |
| 98. List all treating physicians, name of medical group, and city, state where treatment was received. If none, check here: <input type="checkbox"/> No treatment. | | | | | | | |
| 50a. First name, if known | 50b. Middle Initial, if known | 50c. Last name, if known | 50d. Suffix, if known | 50e. Medical Group | 50f. City, State | 50g. Year(s) of Treatment | 50h. Was this covered by TRICARE |
| | | | | | | _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A |